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The Washington State Veterans PTSD Program

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King County Veterans Mental Health Initiative Passes

The major news in the veteran community is the recent election result in King County. Exceeding all expectations, the general election balloting has resulted in the passage of a real estate tax increase aimed at supporting services to veterans. The bill will increase the property assessment throughout the county and then split the collected funds with other social service agencies who serve the general public. Essentially, the funds will be divided "50-50" and result in what is considered to be a 6.5 million dollar pool of money for each entity. One observer, expressing delight in the outcome, considered the desire to help veterans and family members the reason for the favorable voting outcome. In truth, passage of this referendum creates what will be a period of speculation and planning regarding the exact uses of these funds. There is not explicit time-table at this point for use of any money collected. It is likely that no funds will be available before June 2006. TS ##

John King, WDVA Director Retires

After eight years at WDVA and thirty years of state government service, WDVA Director John King hangs up his spurs. Talking with John finds him looking forward to the change of pace, but at the same time you get the very strong feeling that John is considering a number of possibilities for his future work with veterans. Himself a Vietnam War veteran, when John King came to WDVA, he clearly discovered that he had found a place to apply his veteran experiences. As we bid John King farewell, we wish him the very best gifts of family and retirement. TS ##



Governor Appoints John Lee as New WDVA Director

Anticipating John King's retirement, Governor Christine Gregoire selected John Lee as the new director of WDVA. This changing of the guard occurred officially on the first of November 2005. We fully anticipate that in the months and years to come our agency, small by state standards, will continue to follow a unique path on behalf of veterans and their family members. John Lee brings 16 years of service to veterans at WDVA, as well as a career in the US Army. The state PTSD Program is poised for new directions and service efforts on behalf of all veterans. The current war in Iraq, in Afghanistan, as well as the conflicts comprising the Global War on Terror in half a dozen other theaters around the world, will require significant flexibility and creativity to identify and serve those returning veterans needing war readjustment counseling and other services. John Lee has been in the center of the effort for the past three years—to create a service model that evolves almost weekly reflecting our dedication to serve the veterans of Washington State. Congratulations, John! TS ##

Book Review:

Broken Spirits: The Treatment of Traumatized Asylum Seekers, Refugees, War and Torture Victims, by John Wilson and Boris Drozdek

Reviewed by Tom Schumacher

John Wilson and Boris Drozdek edit *Broken Spirits—The treatment of traumatized asylum seekers, refugees, war and torture victims* (2004), offering articles written by 47 authors, some whose names are familiar, others not. The twenty-five articles are organized into seven sections introduced by Wilson. These chapters range widely over the topic specified in the book's title.

Part I looks at "Theoretical, conceptual, and socio-cultural considerations." Part II examines the notion of "Broken Spirits: Traumatic Injury to Culture, the Self, and Personality." Part III examines "Treatments for PTSD: Guidelines for Practitioners." In this section several writers from the international venue offer insight into the experience of refugees, asylum seekers, and victims of torture and war. Wilson looks once more at the role of the therapist and the evolution of the inevitable countertransference issues that result from working with the client's trauma story. Wilson appears to draw a great deal from his own exposure to stories that have gripped him personally. His vivid retelling of some of these stories seems his way of grabbing the reader's attention, and then flooding the reader with the whole array of Wilson's years of work on countertransference in psychotherapy, including an impressive array of concepts and notions. Examples include, "psychobiological synchrony: the basis of empathic attunement, matching-phenomena, and response congruence;" as well as a host of other notions that Wilson has reported upon over the years to inform therapists of the costly wages of mismanaged countertransference issues.

Also helpful in this section is the chapter by Johan Lansen and Ton Haans, "Clinical Supervision for Trauma Therapists." This offering examines the role of supervisors and new-to-trauma therapists, and some of the processes of learning to become or to maintain an effective treatment alliance with trauma survivors.

Part IV, "Nonverbal and Experiential Therapies," offers an array of interesting readings about what we might have called in the 1970's and 1980's, the right lobe therapies. The roles of movement, physical action, body-emotion links, metaphor, art, and music in the treatment of trauma with a variety of trauma survivors, are reported upon by an array of practitioners whose names reflect areas of the world that now specialize in the treatment of trauma of those who have survived war, torture, or have sought sanctuary. While the topics offered are important to the process of therapy, it is perhaps reflective of the tone of this entire book generally that nothing was noted regarding the nature of humor or mirth as a tool for engendering mastery or hope. No author looked at the enormous power of reflective-irony as it operates within the construct of resilience, and the path to improvement. Perhaps these elements are only evidence of "empathic enmeshment" and a general loss of therapeutic boundaries. Not to have consider these very human attributes and necessary defenses is to have missed something very unique to humans.

Part V examines special populations, gender, and developmental issues, while Part VI surveys the special medical, surgical, and clinical issues in the treatment of refugees and torture victims. Part VII looks at the important issues of legal, moral, and political factors that will have a major impact upon the treatment process. These issues can have application for therapists who are seeing veterans suffering from war trauma while still serving in the National Guard or remain on active duty with the military, and once again face deployment to a combat zone. The professional role of the therapist, the ethics of advocacy, ones own political views, and the desire to protect the patient/victim/survivor, are all elements that are considered in this section and have application to our work.

John Wilson and Boris Drozdek bring an important collection of articles to the reader of trauma literature and to therapists who have the potential of seeing specific forms of trauma reflecting the cruelty witnessed in this volume. At \$59.95, this volume has the potential of doing a bit of damage to your budget, but it will be one of the more interesting volumes that you will likely read in a while. ##

Book Review:

Psychological Assessment of Adult Posttraumatic States: Phenomenology, Diagnosis, and Measurement
By John Briere, Ph.D.

John Briere has published a second edition of *Psychological Assessment of Adult Posttraumatic States: Phenomenology, diagnosis, and measurement* (2004). Briere's first edition (2002) was an attempt to pull together many sources of research and clinical experience having to do with assessment tools of post-traumatic stress. The current volume offers updated information, and additional assessment inventories and instruments. Briere reports on a wide range of traumatic experiences and post trauma reactions, to include more complicated reactions. The current volume seems a bit more like Briere's presentations at conferences and workshops. He offers a larger perspective on the impact of trauma, and the cultural context and meaning of the traumatic experience and its clinical expression. The book is worthy of most professional libraries needing additional reference sources. I particularly liked Chapter 8, "Putting It All Together: Assessment of Pretrauma, Functioning, Traumatic Events, Moderating Influences, and Posttraumatic States. At \$34.95, Briere's second edition will not break the bank, and is better than the original. A rare example of the benefits of waiting for a better deal. TS ##

Treating Posttraumatic Dysregulation of Consciousness

As part of a major emphasis on complex PTSD in the *Journal of Traumatic Stress* [2005, 18(5), 437-447], the treatment of complex posttraumatic self-dysregulation was discussed in detail. Authors Julian Ford, Christine Courtois, Kathy Steele, Onno van der Hart, and Ellert Nijenhuis describe various kinds of self-dysregulation as found in DESNOS: "dysregulation in consciousness (e.g., pathological dissociation), emotion (e.g., alternating between rage and affective emptiness), behavioral self-management (e.g., dangerous impulsive risk taking), bodily functioning (e.g., somatoform disorders), self-perception (e.g., believing oneself to be permanently damaged), interpersonal functioning (e.g., alternating between enmeshment in and devaluation of primary relationships), and sense of purpose in life (e.g., loss of sustaining spiritual beliefs). The authors propose a "phase-oriented integrative model to guide the provision and evaluation of psychotherapy for complex posttraumatic self-dysregulation" (p. 437). They point out that this model of PTSD treatment "is based largely on clinical experience and has not been validated by scientific research" (p. 437).

Ford, et al., outline three phases: 1. Engagement, Safety, Stabilization, 2. Recalling Traumatic memories, and 3. Enhancing Daily Living. They explain in detail the process of each phase, and emphasize that the phases are unique for each client, sometimes not pursuing phase 2 when the situation warrants.

"The three phases involve (1) developing a working alliance, enhancing safety by stabilizing suicidality, impulsivity and pathological dissociation, and acquiring or accessing core self-regulatory skills, adaptive beliefs and relationships that were lost or never attained in earlier development...; (2) recalling trauma memories with a goal of achieving 'mastery over memory,'...—a more inclusive, emotionally modulated, and organized autobiographical memory and a more mindful and self-determined orientation to present living and future planning; and (3) enhancing meaningful ongoing involvement in viable interpersonal, vocational, recreational, and spiritual relationships and pursuits" (p. 438). Ford, et al., observe that the phase-oriented treatment "often takes the form of a recursive spiral." "The issues addressed and biopsychosocial processes involved in each phase frequently are returned to in subsequent phases. For example, the shame, guilt, and disgust associated with a sense of being damaged or a terror of rejection, betrayal, and abandonment tend to emerge anew in each treatment phase even after apparently having been dealt with in earlier phases of treatment." They summarize their statement by adding, "Across all theoretical models of psychotherapy, phase-oriented trauma treatment involves enhancing the recognition (rather than avoidance) of posttraumatic self-dysregulation in tolerable ways and amounts in order to promote proactive self-regulation" (p. 438).

Ford, et al., discuss each treatment phase in detail and add 5 treatment "principles" in pursuing the phases, that they present as "precautions" which they assert hold true for psychotherapy in general. "First, *treatment must enhance the client's ability to manage extreme arousal states.*" "Second, *treatment should enhance the client's sense of personal control and self-efficacy.*" "Third, *treatment must assist the client in maintaining an adequate level of functioning consistent with her or his past current lifestyle and circumstances.*" They add, "Emphathizing with the client's struggle with fundamentally altered self-perceptions is done in the service of growth, not to confirm or reify a sense of disability." "Fourth, *treatment must enhance the client's ability to approach and master rather than avoid experiences (internal bodily-affective states as well as external events) that trigger intrusive reexperiencing, emotional numbing, and hyperarousal or hypoarousal.*" To this they add, "avoidance is a hallmark of traumatic stress disorders, and resolving avoidance is a benchmark for successful treatment." "Fifth, *therapists must be aware of and effectively manage clients' transference reactions and countertransference*" (pp. 441-442).

Ford, et al., then review several "manualized treatment models": Cognitive-Behavioral Therapy and Interpersonal Self-Regulation and Affect Regulation Therapy Models.

The authors return at the end of their article to discuss the problem of timing in exploring trauma memories, which is the substance of their phase 2. "The psychic and somatic integrity of the person should never be compromised by attempts at the mastery of traumatic memories. No treatment for trauma survivors fails to acknowledge the primacy of the survivor's integrity, but the priority of that first principle requires vigilant attention in the delicate second phase of therapy" (p. 445). They observe that the tools learned in other phases of treatment can be applied to the management of trauma memories, when they are approached. They warn the reader, "at present, we simply do not have sufficient scientific or clinical evidence to determine whether it is necessary to directly address traumatic memories for PTSD treatment to be effective" (p. 445).

Ford, et al., make an important observation for therapists who regularly treat PTSD to make distinctions between dysregulation problems that may be developmental or attributable to other stressors. The phase-oriented model of treatment gives the practitioner the flexibility to deal with the unique presentation of each client, allowing the therapist to address the most pressing issues as they are deemed necessary, with the knowledge that it is sometimes appropriate to return and readdress traumatic memories with newly acquired information and coping skills. The key question, they wonder, is whether enhancing self-regulation alone can remediate or reduce severity of PTSD. EE ##

Journal of Traumatic Stress Studies Complex PTSD

The October 2005 issue of the *Journal of Traumatic Stress* has devoted attention to the issue of complex PTSD. It employed guest editors Drs. Bessel van der Kolk and Christine Courtois, who introduced the issue by stressing the controversy connected to the division between the PTSD research, which tends to exclude comorbid disorders and the common occurrence of such disorders in everyday clinical practice [18(5), 385-387]. The editors observed a common concern in the treatment of PTSD: "Many clinicians do not find the existing PTSD research literature or treatment guidelines helpful in their day-to-day treatment of traumatized individuals. The disparity between existing treatment research samples and actual clinical populations may account for the fact that many clinicians treating patients with complex presentations continue to adhere to treatment models that are not supported by empirical research, but rather, are based on accumulated clinical experience.... Of necessity, clinicians have learned to focus more on issues of patient safety, affect regulation, coping and self-management skills, as well as on the therapeutic relationship itself, rather than on the processing of traumatic memories, the focus of most empirical research with PTSD patients. At present, the clinical consensus model for the treatment of patients with complex trauma histories is sequenced and progressive. It involves three primary phases, each with a variety of healing tasks: (a) symptom reduction and stabilization, (b) processing of traumatic memories and emotions, and (c) life integration and rehabilitation after trauma processing..." (p. 387).

DESNOS

The two lead articles in the issue focused on two versions of the debate over terminology. Bessel van der Kolk, Susan Roth, David Pelcovitz, Susanne Sunday, and Joseph Spinazzola explored the issue of the so-called DESNOS [Disorders of Extreme Stress: The Empirical Foundation of a Complex Adaptation to Trauma, 389-399]. The authors regret that "in the PTSD literature, psychiatric problems that do not fall within the framework of PTSD are generally referred to as 'comorbid conditions,' as if they occurred independently from the PTSD symptoms" (p. 390). Van der Kolk, et al, list the symptom subcategories of DESNOS on page 391, and describe the DSM-IV Field Trial that attempted to establish the validity of DESNOS as a diagnosis on a large sample, using a comparison group.

The subcategories of DESNOS listed by Van der Kolk, et al, are: alteration in regulation of affect and impulses, alterations in attention or consciousness, somatization, alterations in self-perception, perception of the perpetrator, relations with others, and alterations in systems of meaning.

The authors reported two findings that were remarkable: "The field trial demonstrated that (a) early interpersonal traumatization gives rise to more complex posttraumatic psychopathology than later interpersonal victimization; (b) these symptoms occur in addition to PTSD symptoms and do not necessarily constitute a separate cluster of symptoms; (c) the younger the age of onset of the trauma, the more likely one is

to suffer from the cluster of DESNOS symptoms, in addition to PTSD; (d) the longer individuals were exposed to traumatic events, the more likely they were to develop both PTSD and DESNOS, and (e) although the community sample and the treatment-seeking sample had approximately the same prevalence of PTSD symptoms, almost half the treatment seeking also met criteria for DESNOS, suggesting that DESNOS symptoms, rather than PTSD, may cause patients to seek treatment" [p. 395].

Van der Kolk, et al, criticize psychiatric research into PTSD. "Lack of assessment of other sequelae, or worse, the systematic exclusion of individuals with complex adaptations to trauma from PTSD outcome studies is likely to interfere with exploring the most effective treatments for the most severely affected traumatized individuals" (p. 395). They assert that relegating posttraumatic symptoms other than PTSD to comorbidity may "interfere with a comprehensive and effective treatment approach" (p. 396).

Complex PTSD

John Briere and Joseph Spinazzola next presented a look at the subject of complex PTSD [Phenomenology and Psychological Assessment of Complex Posttraumatic States, 401-412] and note that environmental variables may play a role in how PTSD is expressed. They cited such variables as lower socioeconomic status, stigmatization associated with certain traumatic experiences, inadequate social support, and what they refer to as "idioms of distress" that are acceptable within a given culture (p. 402).

Briere and Spinazzola list the phenomenology of complex PTSD as altered self capacities, cognitive and mood disturbances, overdeveloped avoidance responses, including dissociation (depersonalization, derealization, fugue states, and dissociative identity disorder), substance abuse, tension reduction (sexual behavior, bingeing and purging, self-mutilation, suicidality), somatoform distress, and posttraumatic stress. Referring to the last item, they point out that "somatic symptoms may serve as an idiom of posttraumatic distress for culture or subcultures that deny or reinterpret psychological dysfunction" (p. 403).

Outcome Research

Joseph Spinazzola, Margaret Blaustein, and Bessel van der Kolk [Posttraumatic Stress Disorder Treatment Outcome Research: the Study of Unrepresentative Samples? 425-436] authored a general review of research into PTSD treatment outcome research. They again point out the very high rates of comorbidity with PTSD (80%). They note that "Comorbid conditions are, however, among the most frequent exclusion criteria for participation in PTSD efficacy research" (p. 426) and state that such exclusions result in "artificial homogeneity" that threatens the external validity of study findings. They cite epidemiology studies showing the most frequently found disorders comorbid with PTSD: major depression, alcohol and drug dependence, phobias, suicidality, bipolar disorders and psychoses. They summarize the problem: "While stringent inclusion and exclusion criteria are hallmark features of most efficacy (Continued on page 5, see *Complex PTSD*)

(Complex PTSD. Continued from page 4.)

research, investigators of various Axis I disorders have noted that participants screened out of efficacy studies may in fact be distinguished by symptom severity, comorbid conditions, and demographic characteristics representative of typical treatment-seeking individuals with these disorders..." (p. 427).

In their review of the research, specifically related to the establishment of the ISTSS Practice Guidelines, Spinazzola, et al, report: "Five of the most common criteria excluding potential participants related to the presence of comorbid or severe pathology, with the remaining two concerned with medical problems or past or concurrent use of psychotropic medication. It is noteworthy that the latter two criteria are often a proxy for more complex adaptation to chronic trauma exposure..." (p. 429). The authors found that newer research into PTSD used similar exclusionary data. "The successful application of these newer studies substantiates the contention that efficacy findings from the body of research comprising ISTSS Practice Guidelines are likely to be more generalizable to typical trauma patients encountered in clinical practice settings than can be established on the basis of data provided in published reports of the guideline studies. Nevertheless, this newer research used similar exclusion criteria to earlier studies. Accordingly, the efficacy of these interventions remains largely untested for individuals exhibiting more severe forms of comorbid psychopathology either that have been found to co-occur frequently with PTSD, or for which the presence of PTSD engenders elevated risk" (p. 434).

Spinazzola, et al., call for more thorough reporting of research sample characteristics and enrollment data. They also call for more diverse samples, and the reporting of trauma histories. They suggest that research establish treatment outcome data on more impaired trauma survivor populations and address "more complex symptom presentations." The authors also ask that journals publish negative findings. They write: "This is particularly relevant for studies evaluating the efficacy of empirically untested psychotherapeutic interventions, or medications yet unapproved for PTSD, that nevertheless are frequently administered in clinical practice to traumatized individuals" (p. 435).

Comment

The use of the term complex PTSD seems to sound better than the awkward term DESNOS (Disorders of Extreme Stress Not Otherwise Specified), which may never catch on. The "not otherwise specified" is too much of a catchall phrase that leaves a ring of ambiguity. Complex PTSD, a term first used by Judith Lewis Herman, allows for the many specified "alterations" criteria that is specified by DESNOS, and keeps the focus on the core problem generated by the hyperarousal and memory components of PTSD in focus. EE ##

Stress

Robert Sopolosky, writing in the *Scientific American* [Taming Stress, 2003, 289(3)], defined stress: "a stressor is anything in the environment that knocks the body out of homeostasis, and the stress response is the array of physiological adaptations that ultimately reestablishes balance" (p. 85).

Webster's Deluxe Unabridged Dictionary [2nd Ed., 1983, p. 1801], defined stress from several positions: strain, pressure, the intensity of such force, and the resistance or cohesiveness of a body resisting such force. A second definition refers to urgency, importance and significance. A third definition refers to tension or strained exertion. Other definitions refer to music, prosody and phonetics. These definitions have in common the use of stress as giving accent or emphasis.

Thus, under one word is a combination of the force of that which causes stress and the impact or emphasis that it has. Stress is both the perception of pressure upon oneself and the reaction to the pressure. If an event is a cause of stress, so is the reaction to that event. The memory of a stressful event is itself experienced as stress. It is even conceivable that the memory of a stressful event, given lots of attention and additional associations, could be more stressful than the event itself, as when one contemplates not just what did happen, but what *could* have happened or what happened to others. This was a caveat for those doing debriefing following the 9/11 attacks. It is with the addition of memory that stress has the potential of becoming cumulative, building beyond one's ability to adapt.

One wonders how the use of the word has increased in our society over the years. How many times was the word used in a given edition of the *New York Times* at the turn of the 20th Century compared the beginning of our present century? What role has technology and population increase had on the experience of stress? Is it always progress when something is speeded up or when we know more? Is the writing of a letter with pen and paper, placing it in an envelope and dropping it in the mailbox easier in terms of stress than electronic "instant messaging"? Whereas, in Thomas Hardy's time a farmer used the same tool his ancestors used, in our time ones electronic and mechanical tools are deemed obsolete before one finishes paying the bills for them. EE ##

RAQ Retort

The *Journal of Traumatic Stress* doesn't invite comment, but we do. If you find that you have something to add to our articles, either as retort or elaboration, you are invited to communicate via letter or Email. And if you have a workshop or a book experience to tout, rave or warn us about, the *RAQ* may play a role. Your contributions will make a difference. Email or write to WDVA.

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On Gawking

The head-turning fascination for calamity is repeated daily in the traffic jams created by accidents. Even traffic in the unaffected lanes going the other way is slowed by gawking drivers. In PTSD psychotherapy the therapist must deal with clients who have been traumatized by calamities, sometimes on a scale of national historical significance: war, natural disaster, terrorist attacks. The details are as fascinating as a traffic accident for those hearing stories second hand. I have seen therapists at international conferences relate anecdotes with the kind of second hand authority of almost having been there, borrowing, in a sense from the importance of their clients' experiences and the magnitude of their suffering. The difference between psychotherapy and morbid curiosity (gawking) is in the mind of the therapist.

It was a challenge for me to be caught up in the Vietnam War as a second hand participant. It was difficult to be objective after hearing the stories of the real participants. After the 9/11 terrorist attacks I had the experience of doing my job as a psychotherapist and participant. And then came the War on Terror and the invasion of Iraq. News media replayed terrific scenes hypnotically savoring each scoop as if it were a sports feat. I and my clients are affected by the same events and I cannot separate my counter transference from my own experience with the events.

It is not all bad, of course. This sharing of events with clients can give us a common touchstone with which to compare reactions. It is worse, I think, when the client was there and I was not: war veterans, victims of torture, the New Yorker at Ground Zero, the evacuee from the coast who saw the storm like Dorothy's tornado. I was in the Height-Ashbury of San Francisco as a volunteer in a street clinic in 1967. I talked to victims freaked out on bad acid and strychnine in Golden Gate Park. I have acquired status by association with my clients. I witnessed an historic event taking place and I, who never ingested acid, have absorbed it into my identity.

Gawking for the automobile operator results in the slowing of traffic, and I think we can drive this metaphor further by suggesting that it slows down psychotherapy as well. The therapist, like the driver, is not watching the road ahead when his or her interest is on the accident. It means that the therapist is not watching the clock, gauging the time remaining as the so-called therapeutic window slowly closes.

Historic events are hard to detach from, because we too participate at some level. The images grab our attention and we have a vicarious attraction to the experiences as they are related. When the client rages about gasoline prices, we can share his pain, but when the client is describing a horrendous escape from a near-death experience, witnessing first hand what we heard about and read about and watched on TV replays, that story threatens to move us beyond detachment. Yet we cannot duck the work because we are touched by the client's experiences. Counter-transference emotions can be monitored and intellectually processed through case conferencing. Empathy is, in a way, an opinion about how we feel about the client's experiences. EE ##

The Co-occurrence of PTSD and Psychotic Symptoms

Using a nationally representative sample, a largely Canadian research team examined several questions related to the co-occurrence of PTSD and positive psychotic symptoms, such as auditory hallucinations and delusions. Jitender Sareen, Brian Cox, Renee Goodwin, and Gordon Asmundson published their findings in the *Journal of Traumatic Stress* [2005, 18(4), 313-322]. The authors took their data from the U.S. National Comorbidity Survey (N=5,877) with an age range of 15-54 of non-institutionalized civilians. In-person interviews were conducted in participants' homes, averaging more than 2 hours in length.

Severe PTSD

Sareen, et al, concluded that PTSD "was found to be strongly associated with endorsement of psychotic symptoms." Their findings, they wrote, "suggest that experience of psychotic symptoms among PTSD respondents was not simply due to comorbid mental disorders and general medical problems or sociodemographic factors" (such as age, race, income, etc.) "We found that psychotic symptoms among PTSD subjects were associated with a greater total number of PTSD symptoms" (p. 317). Authors stated that their findings led them to conceptualize psychotic symptoms as a severe form of PTSD.

In their discussion of their findings, Sareen, et al., noted that the diagnosis of psychosis or PTSD depends on how the observer attributes the symptoms. "For example, if someone reports that they (sic) hear voices of an unknown real man criticizing them in the third person (e.g., 'She is ugly') and does not make a connection between these distressing experiences and previous sexual abuse, it is highly likely that this would be viewed as positive psychotic symptoms. However, should the same experience be interpreted as an intrusive memory that sounds real, but is in fact connected to sexual experience in the past, then a diagnosis of PTSD is more likely..." (p. 320).

The authors state that "the types of traumatic experiences that were associated with psychotic symptoms among PTSD respondents included being in a disaster, witnessing someone being badly injured or killed, and great shock because one of the traumatic events happened to someone close to the respondent" (p. 319). They note further that the total number of traumatic events was "also associated with psychotic symptoms among PTSD respondents."

Comment

It is sobering to consider that the most severe cases of PTSD, those with psychotic symptoms, are commonly excluded from research on PTSD treatment because they confound results. Yet these are among the clients we must treat week after week. EE ##

PTSD and Quality of Life

Many of the clients seen in the Washington State PTSD Program and the King County Veterans Program have posttraumatic stress disorder from multiple traumas. They range diagnostically from complex PTSD to partial PTSD. They experience a variety of health related problems, such as diabetes, cancer, heart attacks, pain syndromes, gastro-intestinal problems, and obesity, along with myriad health problems brought on by a compromised immune system. Clients move away, some die from these and other problems, including heroin and alcohol toxicity, machinery and single car accidents, a few die of gunshot wounds and other mayhem.

The summer 2005 issue of the *PTSD Research Quarterly* is devoted to "Quality of Life" functioning with posttraumatic stress disorder. Steven R. Thorp, Ph.D., and Murray B. Stein, M.D., of the VA San Diego Healthcare System reviewed the recent literature on the subject. They warn the reader that comorbidity of PTSD with other physical and mental disorders "may inflate the functional deficits attributed to PTSD." They quote a 2000 National Comorbidity Survey that "revealed that PTSD was associated with approximately 3.6 days of work impairment per month, which was comparable to major depression (but less than panic disorder)."

The authors refer also to the National Vietnam Veterans Readjustment Study, published in 1990, which found in their very large sample that "male and female veterans with PTSD (compared to those without PTSD) reported poorer physical health, more medical service utilization, and greater work impairment. These veterans were also less likely to be married than those without PTSD, and those who had married reported higher rates of marital problems and divorce." The authors conclude, "these findings highlight the dramatic association between PTSD and poor health functioning."

I had attributed the rate of illness and death among my PTSD clientele to what I thought of as a clinical skew. I saw only the veterans who were having trouble with PTSD, thus they were only a small biased sample of Vietnam War veterans. Occasionally I would meet veterans as clients or socially who were doing well and were prosperous, although we all know that the standard definition of "doing well" may range from no one's shooting at me, to being listed in Who's Who."

The 1990 NVVR study showed a lifetime PTSD rate among Vietnam War veterans as 30% and 15% percent of the very large sample had PTSD (about 500,000) at the time of the study, and we assume a percentage more had partial PTSD. The death rate of Vietnam War veterans is higher than Korean War veterans, which is in turn higher than World War Two veterans, referring of course to comparable ages. It is arguable that the stress of living in a more populated and technology driven society also reflects a correlated increase.

Drs Thorpe and Stein refer to a study published in 2002. Zatzick et al., studying a sample of patients "found that 30% of patients met criteria for PTSD one year after enduring physical

traumas that required being hospitalized for surgery." They note that PTSD "was the strongest predictor of adverse outcomes even after adjusting for age, injury severity, chronic medical conditions, sex, pre-injury physical functioning, and alcohol use."

The *PTSD Research Quarterly* reviewers conclude: "The studies summarized here provide compelling evidence that PTSD is associated with substantial impairment in functioning and ...[quality of life], above and beyond that linked to depression or physical injuries subsequent to trauma."

Joseph Boscarino, Ph.D., publishing in the 2005 *Annals of Epidemiology* [Posttraumatic Stress Disorder and Mortality Among U.S. Army Veterans 30 Years After Military Service,] surveyed 15,288 Army veterans 30 years after military service and found that "postwar mortality for all causes, cardiovascular, cancer and external causes of death (including motor vehicle accidents, accidental poisonings, suicides, injuries of undetermined intent) was associated [$p < 0.001$] with PTSD among Vietnam Theater Veterans."

Comment

Psychotherapist contractors are sometimes criticized for hanging on to clients, when year after year they are dealing with a succession of stressors that turn ordinary living into a struggle to survive. Researchers studying PTSD, in an effort to obtain a pure definable sample, limit the co-morbid conditions that the front line psychotherapist is likely to treat. The proliferation of such studies, with their limited outcome criteria, give the impression that PTSD treatment should be time limited.

The stressors of living, unfortunately, aren't so conveniently limited and are a greater problem for those with PTSD compared to those without PTSD. An excellent research project, one that would be informative for those calculating the true cost of war, would compile the ongoing costs of treating a sample of war veterans with PTSD from the time of their discharges.

On the surface it seems practical to trim the costs of the treatment of veterans by stretching out appointments, raising the criteria for what the VA will take responsibility for—such as denying responsibility for smoking related illnesses. At the same time, it is deceptive to pretend that participation in combat is without long term health consequences for many veterans, and it is truly unfair to expect the veterans and their families to bear the burden alone of living in a society that is increasingly stressful with stress-related illnesses that are increasingly burdensome.

The WDVA and King County Veterans PTSD program presents the opportunity for veterans to receive face-to-face emotional support from professionals who are not going to declare, like the Lewis Carroll rabbit running for his hole: "Oh, dear! Oh dear! I shall be too late!" EE ##

Book Review:

Soldiers to Citizens: The G.I. Bill and the Making of the Greatest Generation, by Suzanne Mettler

Reviewed by Emmett Early

Suzanne Mettler is an associate professor political science at Maxwell School of Citizenship and Public Affairs at Syracuse University. Her thesis is an interesting one and worth discussing. She presents her research to show that the GI Bill, established at the end of World War II, essentially stimulated a whole generation of veterans to become better citizens by participation in civic affairs.

I must present my bias here: I am a recipient of the G.I. Bill's education benefits and have a Ph.D. to show for it. I can say with circumspect confidence that I would not have gone to graduate school but for the G.I. Bill assistance.

The genesis of the G.I. Bill comes from the World War One veterans' Bonus March. The veterans of that era demonstrated what other countries have found to their regret, that war veterans can organize into powerful coalitions. The ugly fate of Nazi Germany is a testament to this thesis. The frightening message from the Bonus March was felt when it was realized that huge numbers of GIs, 15 million, would be getting discharged in 1945 at the same time about 10 million defense workers were being laid off from unneeded industries. The thought of all those veterans entering the contracting job market was frightening. As Dr. Mettler observes, "among men born in the United States in the 1920s..., fully 80 percent were military veterans" (p. 7). She observes later that, of those veterans, about 2% were women.

Dr. Mettler reminds us that the G.I. Bill was "one of the most sweeping programs ever enacted in the United States" involving 51% of WWII veterans, a total of 7.8 million, who took advantage of the bill's provisions to acquire education and vocational training. Her central thesis is that this sweeping legislation created a wave of civic participation that formed a whole generation of civic involvement. Dr. Mettler's research conducted surveys of over 1,500 veterans, conducting in-depth interviews with 28 veterans "from all regions of the United States." She declares, "Those veterans who utilized the provisions became more active citizens in public life in the postwar years than those who did not" (p. 9).

The author is clear that the G.I. Bill largely benefited white males who served in the military more than 6 months. Black veterans also benefited, although their participation was severely limited by *de facto* and *de jure* racial discrimination. The G.I. Bill education and training benefits did have an influence on African American veterans in stimulating participation in civic life as a potent force in the civil rights movements (pp 136ff).

Dr. Mettler highlighted the role of the American Legion in promoting and guiding the legislation (p. 18). She notes

that the G.I. Bill was a departure from previous veterans pension programs. "Over time, the Civil War pensions had earned a poor reputation among Progressive reformers, who associated them with corruption. They were delivered through the patronage system of party politics, which permitted a high degree of discretion to local politicians, who could in practice control the timing and targeting of benefits for political purposes. With World War I, policy makers sought to create benefits that would be less expensive, less open to potential abuse, and more oriented toward the promotion of self reliance among veterans. Rather than disability pensions, they offered veterans of the Great War merely the option of purchasing low-cost insurance, and established vocational programs and medical and hospital care for disabled veterans only. This was the approach that veterans viewed as so miserly; it generated repeated demands for outright pension payments and ultimately led to the notorious treatment of the Bonus Army during the Hoover administration" (pp. 18-19).

It was to the credit of the American Legion's leaders that the G.I. Bill became as generous and sweeping as it was, removing wording that would have reserved the greatest benefit for the elite. It was the Legion's influence that gave the bill's benefits of one year of guaranteed tuition and assistance for very year served in the military. Interestingly, newspaper tycoon William Randolph Hearst offered his reportorial resources to assist the Legion in lobbying Congress and generating popular support for the bill.

No one knew quite what to expect when the bill was enacted. Colleges and universities in the United States had been stressed by the war's depletion of students. As Dr. Mettler points out, the university system was mainly used to catering to the wealthy top of the nation's students. Fears were expressed that opening up the universities and colleges to the common man would degrade standards. In fact the recipients of the G.I. education benefits revitalized higher education in the U.S. What changed on campuses was the introduction of a large number of serious, mature students, many of them married, who were bent on studies instead of the leisurely social life of privileged students. Contrary to the Vietnam War era, the military of WWII was comprised of a very large cross section of males from all walks of life. Dr. Mettler emphasizes (p. 35) that only 1 in 16 veterans (fewer than one million) had participated in "extended combat" and "one-quarter of the armed forces served on the home front, never venturing overseas." Thus the G.I. Bill recipients were not necessarily combat veterans, but were definitely a population of largely white males hungry for education and training.

(Continued on page 9, see *G.I. Bill*.)

(The G.I. Bill, continued from page 9.)

Suzanne Mettler does a good job interweaving comments from individual veterans, and gives emphasis to veterans of black infantry divisions. She writes, "By the time World War II veterans' eligibility period for the G.I. Bill use ended, a stunning total of 7.8 million veterans—fully 51 percent of all who had served in the military—had attended school or obtained training on the G.I. Bill. Among them, 2.2 million veterans attended colleges and universities and 5.6 million pursued vocational training, on-the-job training, or other subcollege education" (p. 42). She presents a telling bit of data, showing that the further a veteran went in utilizing the bill, the greater his civic involvement, in the form of membership in civic organizations and political life. She shows through her survey data that veterans thought highly of the G.I. Bill benefits, many considering it a turning point of their lives, regardless of the problems involving administration and even racial restrictions. She asserts that because of the friendly government-sponsoring of generous benefits that were not considered welfare but rather earned, beneficiaries developed a positive attitude toward their government.

Dr. Mettler shows that the fears expressed by some university administrators that the G.I. Bill would turn campuses into "educational hobo jungles" not only did not materialize, but rather, accommodating the huge increase in student populations ("By 1947, veterans accounted for half of the enrolled college students..."), resulted in lasting changes in the way higher education did business. For instance, offering year round curricula, instead of the traditional leisurely summer off. She cites statistics from her own campus, Syracuse University, to show that the student enrollment from 1943 to 1948 increased 650%. She also cites studies which "revealed that veterans earned better grades than nonveterans at the same institutions, and married veterans outperformed single veterans" (p. 71), and adds that three-quarters of the G.I. Bill recipients held some form of employment. The author points out that the veterans of WWII grew up in the Great Depression, and that, over time, "G.I. Bill users emerged as more likely to have experienced a transformation in their life circumstances and to be leading more secure lives than in their youth" (p. 94).

Dr. Mettler gives some substance to the cultural phenomenon observed by the later generations, in which WWII veterans became involved in civic and veterans organizations and consequently involved themselves in the social institutions of their communities. She writes, "The longer the veteran benefited from the provisions, the more political organizations he joined and the more political activities he engaged in during later years" (p. 115). She cogently dispels the on-going myth that welfare creates sloth. "Contrary to our assumptions today that time spent using government programs may produce less vibrant citizens, those who collected the benefits of the G.I. Bill over the longest duration became more active in politics, not less so" (p. 116). She also shows that this was true of African American veterans who became a force in the Civil Rights activism of the 1950s and 1960s. "The benefits enhanced beneficiaries' socioeconomic circumstances and skills in ways that

heightened their capacity and predisposition for civic involvement. As well, they generated strong cognitive effects by offering beneficiaries a highly positive experience of government, one that provided them with resources they judged to be valuable, and treated them with respect in the process. The effects coalesced to incorporate recipients more fully as citizens..." (p.119). She elaborates later, "The point is not that the G.I. Bill alone explains the civil rights movement; certainly most who took to the streets were not veterans, and a wide range of organizational, social, economic, and political factors coalesced to prompt the broader mobilization. Rather, black veterans who obtained advanced education—available to them through the G.I. Bill—were especially likely to become activists and to participate intensely in the political struggles through which civil rights were won. They populated the civic organizations that became the engines for social change, joined the crowds that took to the streets to protest, and took part in the sit-ins. Then, once new rights were at last achieved, they were among the first to exercise them in the realm of formal politics. The G.I. Bill's education and training benefits, being democratic in application, subsequently helped facilitate the development of a more democratic America" (p. 143).

Relevant to our current wars, Dr. Mettler cites her previous research in asserting further that "Congresses containing high proportions of veterans have proven less willing to use American troops than Congresses with fewer veterans, though once the nation has committed itself to armed conflict, the veteran-populated legislatures have supported higher degrees of force in the conflict" (p. 133).

One of the side effects of the G.I. Bill was the creation of a huge domination of one gender. Women who served in the military, albeit only 2% of the total force, faced great obstacles in utilizing the G.I. Bill's benefits. They were seldom even informed of their rights. Women in the military were generally better educated than males and many did not need to utilize education benefits. The bill's provisions did not extend to the spouses of female veterans, as it did for males. The thinking of the time was that male spouses could support themselves. In spite of all the roadblocks, Dr. Mettler writes: "Women genuinely valued the education they received from the G.I. Bill, but given the structure of family life, education, and employment, the program affected their lives far less dramatically than men's."

I can attest to how easy the government made the utilization of the G.I. Bill's education benefits, and I can also affirm that there was no stigma attached to the benefits at the time I used the bill, 1970-77, to become a psychologist. Dr. Mettler notes that the current educational benefits, in which the person in the military contributes part of the funds along with the government, remains a popular recruiting item. Suzanne Mettler's thesis is convincing and deserves respect, that the government, (we think federal or state) can partner with citizens, veterans in our case, to create a better life for all concerned.

EE ##

Movie Review:*Ride the Pink Horse*--WWII Veteran as Flawed CharacterReviewed by Emmett Early

Robert Montgomery directed and starred in this deceptively titled movie about a WWII veteran of the New Guinea campaign, Lucky Gagin, who arrives by bus to the southwestern town of San Pablo. He has come to avenge the murder of his pal, Shorty. Gagin is a tough, dogged, confident, bigoted war veteran. He asks a group of Native American women for directions to the hotel and when one young lady offers to guide him, he refers to her as "Sitting Bull." Gagin tricks the desk clerk into revealing the room number of the gangster who murdered Shorty, Frank Hugo (Fred Clark). He goes directly to the room and rousts the secretary and draws the admiration of Hugo's girl friend, (played by Andrea King,) but the gangster is not there.

Ride the Pink Horse is adapted from a Dorothy Hughes novel by Ben Hecht and Charles Lederer and released in 1947. The title refers to a horse on a carousel. Unable to get a hotel room in the town because of a fiesta, Gagin is directed to *De Las Tres Violetas* and meets Pancho (Thomas Gomez), who runs the local carousel with the pink horse. Pancho offers Gagin his own open-air bed. Pila (Wanda Hendrix), the Native girl he repeatedly calls Sitting Bull with racist derision, persists, for some reason, in helping him. (Perhaps because she's an Anglo actress with dark makeup playing a Native.) When he asks directions, Pila wants to know if he's looking for a friend. Gagin responds, "I'm nobody's friend." A federal cop (Art Smith), who has been investigating Hugo, tries to collaborate with Gagin. Gagin refers to him derisively as "Uncle Sam." The cop is amused and responds to the veteran, "All cussed up because you fought a war for 3 years and got nothin' but ribbons." Hugo, it turns out was a dishonest war profiteer.

Gagin gets attacked by two thugs with knives. He kills one, wounds the other and his badly wounded himself. Pila, of course, helps him. He grows delirious from his wounds and talks about the jungle where it gets so hot, when it rains, it turns to steam."

Gagin is victorious against the gangster, but cannot bring himself to say he cares for Pila. At the end of the film, he walks away with the cop.

Ride the Pink Horse has several elements of PTSD in war veterans: anger, social alienation, reckless aggression. His loyalty is a fierce, nostalgic bond. Everything Gagin does seems to have a hard edge, even when he's being friendly. His racial slurs are expressed in a way that seems both ignorant and defensive. We get the feeling he called every Native American he met in the service Chief or Sitting Bull. His social grace is nil. He seems to relate best behind a well-defended position through which no positive sentiment passes unchallenged. His admirable traits are the combat veteran's valued loyalty and courage. The cop in another of his retorts, tells the veteran, "you sound like a disillusioned patriot." ##

Relationship Found Between Smoking and PTSD

A medical record review of 6,744 pairs of twins who served in Vietnam during the war revealed that those who smoked tobacco were twice as likely to develop PTSD as those who didn't smoke tobacco. Karestan Koenen of Harvard University published her results in the *New Scientist*. The magazine, *The Week* [November 25, 2005], reported that Dr. Koenen found that "veterans who had had a pre-existing addiction to nicotine doubled their chances of coming home with a stress disorder." She observed, "Nicotine stimulates some of the same neurobiological pathways implicated in stress." *The Week* added without quoting her, "smoking apparently primes these pathways so that negative experiences have more emotional impact."

Comment

If Dr. Koenen's research is replicated, the finding that smoking tobacco primes one for PTSD lends weight to the argument that the federal government should take responsibility for passing out free cigarettes to combatants and making cigarettes cheap and readily available at base exchanges.

One wonders, however, if there might also be a confounding variable that both makes an adolescent prone to smoke and susceptible to PTSD. ##

Fed VA Director Wants Review of PTSD Disability Awards

Just a few days after the VA announced cancellation of a plan to review 72,000 PTSD awards, Senator Larry Craig of Idaho, Chairman of the Senate Committee on Veterans' Affairs, stated in a press release, "The Department of Veterans' Affairs announced today that it has contracted with the Institute of Medicine (IOM) on a two-pronged approach to the examination of PTSD. As quoted on a website *oped-news.com* [11/28/2005], Larry Scott obtained from Senator Craig's office information that IOM "...will review the utility and objectiveness of the criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), and will comment on the validity of current screening instruments and their predictive capacity for accurate diagnosis." Mr. Scott added that the IOM "...will review the literature on compensation practices for PTSD...and how changes in the frequency and intensity of symptoms affect compensation practices for PTSD; assessing how compensation practices and reevaluation requirements for PTSD compare with other chronic conditions which have periods of remission and return of symptoms; and reviewing strategies used to support recovery and return to function in patients with PTSD."

Army veteran Larry Scott has his own web access at: larry@vawatchdog.org. EE ##

Movie Review:***Downfall*—World War I Veteran Loses His Grip**Reviewed by Emmett Early

Bruno Ganz plays Adolph Hitler in the 2005 German film *Downfall*, which takes place in and around his Berlin bunker during the last days of the war as the Soviet troops are advancing. Hitler is seen interviewing women for the job of his secretary. The women, probably happy to have a chance at a job, are thrilled to be in the presence of Hitler. He interviews Traudl Junge (Alexandra Maria Lara) and when she flubs his dictation, he is kind and soft with her. But when he is with his generals, he rages, refuses to accept their suggestions, denies the facts and blames others for betraying him. He persists in believing that maneuvers by forces in reserve can save the day. At the same time, he arranges for his and Eva Braun's suicide (Eva is played by Julianne Köhler) and the destruction of their corpses.

Downfall begins and ends with an interview with the real Traudl Junge, who was Hitler's secretary during his last days. The film is based partly on her autobiography, *Until the Final Hour*, which she co-wrote with Melissa Muller, partly also on the book, *Inside Hitler's Bunker*, by Joachim Fest. The screenplay was by Bernd Eichinger. The plot device that introduces the secretary gives us an entry into the closed world of Hitler's inner circle, and a welcomed exit at the end, for she was one of the few who survived.

Bruno Ganz plays Hitler with such intensity that the aftermath of the movie is a vacuum. His left hand has a remarkable tremor, which he holds behind his back, like a dog wagging his tail. His brow is deeply furrowed, his face appears in agony, and his posture is painfully hunched-over. His staff carry out his orders, gradually declining into morose drunkenness.

Downfall was directed by Oliver Herschbiegel. The scenes mimic on a horrific level what must go on in offices of institutions when the workers see their boss acting strangely and have no power to intervene. We see various levels of perceived duty and dedication. Joseph and Magda Goebbels (Ulrich Matthes and Corinna Harfouch), for instance, are so dedicated to Hitler that they imitate his end, killing themselves and their children. The movie ends in a depressing montage of suicides, although some, like Albert Speer (Heno Ferch) weasel out and surrender. Even Hitler's pet dog, Blondi, is euthanized, emphasizing the lesson that faith and loyalty without judgment can be risky.

The war veteran angle plays out in a number of ways among the officers in the bunker. When Hitler dictates to Traudl Junge his last statement, he talks of his experience from World War I almost as if that is when his life began.

Hitler was a messenger in the trenches of that war—by no means a cushy job.

The director does not spare us the destruction and the human misery. Children “man” the anti-tank weapons under the supervision of an armless soldier. A physician walks through basement hospitals amidst calamitous suffering, enfeebled elderly laying with corpses. A radio operator in the bunker watches the downfall with troubled eyes as he sees the drunken madness and suicides. His fate is suggested as he reaches for his pistol.

Eva Braun suggests the fate of many women who are attracted to war veterans only to witness their decline, becoming so enmeshed that they are drawn down as well. Perhaps they were abused as children. Perhaps they cling to his pension. Or perhaps it is undying loyal wishful thinking that takes them too far down the road of illusion.

Eva and Adolph are wed officially by a judge, brought into the bunker in the last hours. The absurdity of the Reich is made salient when the judge apologetically asks Adolph, as he is required to do at such official ceremonies, if he has any Jewish blood.

There is truth, too, albeit exaggerated, that those around Hitler, his generals and aides, who enlisted when they were caught up in the collective madness of the man's perverse romance, grow disillusioned, then desperate, seeing the crushing undeniable reality that the war was lost and their leader has lost touch with reality. Believing in Hitler was their fateful mistake.

One of the best lines is delivered by a general who helps Trudl escape in the end. As they stop amid the rubble he offers her a biscuit. “Eat something,” he says, “there's time enough to die.” A sentiment no doubt observed by many a soldier in combat.

Men and women enlist, believing they are right, then are thrown into combat and to their horror discover that command decisions do not include their safety, and what they initially believed no longer applies. Yet, there they are, in the bunker, their fate wrapped irrevocably in the decisions of others. Traudl Junge confesses her shame that she did not know what Hitler was doing in the concentration camps, yet she was part of the machinery of death and suffering.

The film ends with Traudl Junge riding a bicycle on a country road. The fate of the women of Berlin was not as sanguine, after the invading Soviet troops were allowed to rape with license for weeks after securing the city. ##

“Eat something, there's time enough to die.”

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King County Veterans Program, which also provides vocational counseling and emergency assistance, is located at 123 Third Ave. South, Seattle, WA....206 296 7656.

The King County program works under contract with WDVA to provide PTSD counseling to veterans and family members living in King County.

To be considered for service by a WDVA or King County contractor, a veteran or veteran's family member must present a copy of the veteran's discharge form DD-214 that will be kept in the contractor's file as part of the case documentation. Occasionally, other documentation may be used prove the veteran's military service. You are encouraged to call Tom for additional information.

It is always preferred that the referring person telephone ahead to discuss the client's appropriateness and the availability of time on the counselor's calendar. Contractors are all on a strict and tight monthly budget, however, contractors in all areas of the state are willing to discuss treatment planning.

Some of the program contractors conduct both group and individual/family counseling. ##

The Repetition & Avoidance Quarterly is published each season of the year by The Washington Veterans PTSD Program, of the Washington Department of Veterans Affairs. The PTSD Program's director is Tom Schumacher. The editor of the *RAQ* is Emmett Early. It is intended as a contractors' newsletter for the communication of information relevant to the treatment of PTSD in war veterans and their families. Your written or graphic contribution to the PTSD Program newsletter is welcomed if it is signed, civilized, and related to our favorite topics of PTSD and war veterans. Contributions may be sent by mail to the Washington Department of Veterans Affairs (Attn: Tom Schumacher), PO Box 41150, Olympia, WA 98504, or by Email directly to <emmettearly@msn.com>. Readers are also invited to send in topical research or theoretical articles for the editorial staff to review. Comments on items reported in the *RAQ* are also encouraged and will likely be published if they are signed. To be included in our mailing list, contact WDVA, Tom Schumacher, or Emmett Early. The *RAQ* can also be read online by going to www.dva.wa.gov Once in the WDVA website, click on PTSD, and once on the PTSD page, scroll to where you find access to the *RAQ*. The newsletter logo is a computerized drawing of a photograph of a discarded sign, circa 1980, found in a dump outside the La Push Ocean Park Resort. ##